



ND RYAN WHITE PROGRAM PART B REQUEST FOR VISION CARE

NORTH DAKOTA DEPARTMENT OF HEALTH

DIVISION OF DISEASE CONTROL

SFN 60072 (04-2015)

Client's Name

ND Ryan White Client Number

Date Form Completed

Instructions

Attach estimated cost of procedure from your vision care provider.

All procedures will be covered up to 100 percent. All procedures besides preventive care will be subject to a consultation with vision care provider to determine the need for the procedure, and the ND Ryan White Program Part B will then decide if the procedure will be covered. Glasses will be covered 100 percent up to \$200 biannually.

Type of Assistance Requested

Vision Care Provider's Information

Provider's Name		Telephone Number
Address		
City	State	Zip Code

Explanation of Vision Care Procedure (To be completed by vision care provider.)

Signatures

_____ Client	_____ Date
_____ Case Manager	_____ Date

Approval by ND Ryan White Program Part B Coordinator

☐ Yes ☐ No